~~CONFIDENTIAL~~

HEALTH SERVICES STAFF CONFERENCE

Cincinnati, Ohio
March 29 through April 3, 1943

Conference Committee Reports

I. The Environmental Sanitation Program

II. The Present FSA Health Program

III. The War and the FSA Health Program

IV. The Extension of Rural Health Services

Note: The Discussion sections appended to the end of each committee report constitute condensed versions of certain salient and significant points brought out in the discussion of committee reports or at other points during the conference.

I. THE ENVIRONMENTAL SANITATION PROGRAM

Committee Members

George T. Kester, Dallas, Texas, Chairman

Maurice L. Cotta, Portland, Oregon

Robert Eddy, Little Rock, Arkansas

Paul P. Maier, Indianapolis, Indiana

George Montgomery, Montgomery, Alabama

Herbert M. Russell, Little Rock, Arkansas

Ivan F. Shull, Washington, D. C.

Responsibilities

A. Prepare a program for completing, by June 30, environmental sanitation improvements covered by present grant funds, taking into consideration the problems of priorities, the use of noncritical materials, and workable techniques for getting the job done at the local level.

B. Draft an environmental sanitation program, designed for the duration of the war, which will point up problems to be solved in the post-war period. To this end, the committee will be expected to give proper emphasis to the use of substitute materials and the development of simple and inexpensive methods which can be worked out by an individual farmer or group of farmers in solving environmental sanitation problems. Suitable educational material should also be considered.

C. Explore educational techniques and other ways and means of carrying through to the borrower families the place of environmental sanitation in the prevention of disease, particularly now, when both public and private medical facilities are taxed to capacity.

D. Develop standards for meeting sanitation and housing needs of seasonal and year-round farm workers.

COMMITTEE REPORT

A. Completion of Sanitation Improvements Financed by Grant Funds

The committee felt that the Administrator's letter to the Regional Directors instructing them to complete all sanitation construction by June 15, 1943 or return the grant fund to the U. S. Treasury, (except in cases where the Regional Director approved, contracts had been let, and construction could be completed by September 15) was reasonable and appropriate.

In order that the maximum accomplishment of sanitation improvements be made with funds at hand, the committee recommends that:

1. Conferences be held at regional and state levels with one or more of the following groups or officials for the purpose of developing a plan of action:

   a. Regional Coordinating Committee

   b. Regional Sub-committee on Health

   c. Assistant Regional Director in Charge of Rural Rehabilitation

   d. State Director and his staff

2. Determine where technical and administrative assistance is needed and provide the same by:

   a. Securing reports immediately from each county as to the amount of funds remaining unexpended and the amount of work remaining to be completed.

   b. Send instructions and illustrative material to the field where needed, showing proper methods of construction.

   c. Visit counties where difficulties in securing suitable material and labor exist and assist county personnel in making necessary arrangements for material and labor.

   d. Develop a monthly Progress Reporting System for all counties from which the amount of sanitation grant funds remaining unexpended in every county can be determined and the progress being made in expending them known. Use FSA Instruction 356.2, Exhibit K, pp 1-2, and County Progress Report 322.

   e. Submit annual reports as of June 30, 1943, using FSA Instruction 356.2, Exhibit L.

B. Farm Labor Sanitation

The committee feels that standards of housing and sanitation for year-round farm-workers should be such as will give reasonable assurance that neither the health of the worker and his family nor that of the community in which he works will be jeopardized through lack of the proper basic sanitary safeguards. These include a sanitary privy, a

protected water supply and a screened home.

It is recommended that the Sanitation and Housing Standards (dated March 12, 1943) developed by the Office of the Chief Medical Officer, or their equivalent, be used by the various regions in connection with the Year-round Farm Labor Program. The Sanitary Engineer, accompanied by the RR or HM Supervisor, should spot-check housing and sanitation after families have been placed.

Sanitation standards for seasonal farm workers should be developed jointly by the Sanitary Engineer, Management Division personnel, the District Engineer, the Labor Relations Division personnel , and Home Management personnel.

C. War-time Program

The committee realizes that following the expenditure of the present grant funds by June 15, 1943, there will be a tendency for County Supervisors to feel that nothing more can be done about improving the environmental sanitation of the borrower families. To counteract this tendency, the committee recommends that the Health Services Staff should do as follows:

1. Develop immediately an outline for a War-time Environmental Sanitation program to encourage our borrowers properly to repair and maintain existing sanitation facilities.

2. Discuss this program with the Regional Coordinating Committee and integrate it into the future FSA rehabilitation program.

3. Discuss environmental sanitation at Area, District and County meetings in order that local FSA personnel may be better able to encourage families to improve their sanitation facilities , themselves, using farm income and loans where necessary.

4. Sanitary Engineers should compile lists of suitable substitute materials and outline proper methods for use by families.

5. Locally available materials should be utilized to the utmost during this period of wartime shortages.

D. Future Environmental Sanitation Program

1. Scope - In developing a program for the post-war period the committee felt that the three items which comprise the environmental sanitation program now should be considered a minimum and therefore provided for all families where needed.

   In addition the committee recommended that construction of more convenient and desirable facilities be permitted, provided the cost of such construction could be financed through loans or cash contributions of the families. Similarily the committee felt that the program should permit the construction of food storage facilities where needed and where families are able to pay for them either through loans or cash contributions.

Environmental sanitation should by all means be included in the Experimental Health Programs.

2. Organization - The committee recommends that the sanitation, medical and dental care programs be integrated into a coordinated over-all health program to be administered by health associations.

The following services should be provided by health associations in connection with this environmental sanitation work:

a. An effective educational program to inform the member families concerning proper construction, use, and maintenance of sanitation facilities.

b. A sanitarian-foreman who, in close cooperation with the state and local health departments, can appraise the sanitation needs of the family, estimate the cost of the improvement, and assist the family in the actual construction.

c. A system of records and accounts.

The committee believes that the present method of issuing grants to individual families to be used for specific purposes is rather tedious and time consuming. As an alternative it is suggested that the grant needs of all the families be computed and a grant be made to the association directly, subject to strict accounting.

3. Financing - The committee recommends that, during the next year considerable thought be given to suitable methods of financing. It appears that the success or failure of the environmental sanitation program hinges upon the development of a satisfactory method of financing. In the following respects environmental sanitation differs from medical care:

a. The initial cost is comparatively high.

b. It is not an annually receiving cost.

c. The benefits stay with the owner so that tenants are reluctant to make improvements.

The committee felt, therefore, these measures were essential:

a. Long term, low interest-bearing loans for sanitary improvements.

b. In the case of tenants or sharecroppers, greater landlord contribution or long-term leases or both.

c. Some local subsidy in addition to federal subsidy in areas where subsidies are needed.

d. Altering the present procedure of making grants to families to permit the sum-total of all grants needed to be made to an association.

4. Materials - The committee hesitates to mention suitable materials. Doubtless, many new plastic materials will be developed during the war and will, in many instances, be better than the ones now being used. Light weight materials and prefabrication will probably be available.

The committee feels that during the coming year, efforts should be made, particularly by the Sanitary Engineers, to inform commercial interests concerning the sanitation problems of rural areas in order that suitable products may be made available and unsatisfactory products discontinued. Manufacturers of pumps and other supplies should be familiarized with the FSA program and its problems.

E. Educational Efforts

The committee felt that the educational efforts of FSA in connection with its environmental sanitation program had been very inadequate. The committee believes that responsibility for this educational phase of the program has been left almost exclusively to local and state health departments. Therefore the committee recommends that:

1. The Health Services Staff make a greater effort to see that suitable educational material is available in all county FSA offices and that provision is made for presentation of such educational materials to the families through the Health Associations.

2. RR and HM Supervisors inspect the sanitation facilities during each visit and discuss any needed improvements with the family.

3. The services of FSA nurses (project, labor camp, and experimentals) be enlisted for educating the farm public on the need for better sanitation.

4. The cooperation of the following persons and facilities should be enlisted for promoting the sanitation program on the county level.

   a. FSA County Health Associations

   b. Physicians participating in health programs

   c. Neighborhood action groups

   d. Experimental Health Program

   e. Vocational agricultural organization

   Visual education and literature should be used in these programs. It is hoped that environmental sanitation may be included as an essential part of every farm plan.

DISCUSSION

Immediate Action

It was the general understanding of all the sanitary engineers that the directives of this report will be put into prompt execution, immediately upon the return of all personnel to their regions.

Public Health Service Sanitary Engineers

The conference learned with pleasure that four sanitary engineers had been loaned to the Farm Security Administration to assist in expediting the sanitation program with the funds available until June 30, 1943.

Health Association Sanitarian-Foremen

It was the evident intention of the Committee that a sanitarian-foreman be engaged by county health associations only in cases where local official health department sanitation programs are inadequate or utterly lacking. There is, of course, no intention to duplicate the services of already functioning agencies so long as these agencies are able to furnish the necessary advice and assistance to members of the health associations.

Use of Locally Available Construction Materials

Discussion of sanitation problems emphasized the valuable results of making personal contacts with local lumber yards and other such material sources. Many of the difficulties of presumable wartime shortages will be found to disappear, it was pointed out, when direct contact is made by the sanitary engineer with the local dealers in construction materials.

II. THE PRESENT FSA HEALTH PROGRAM

Committee Members

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H. M. Guyot, Raleigh, North Carolina

John W. Kennady, Upper Darby, Texas

Joseph A. McElligott, M.D., Milwaukee, Wisconsin

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Edward W. Neenan, D.D.S., Denver, Colorado

Leah Resnick, Washington, D. C.

Jesse B. Yaukey, Washington, D. C.

Responsibilities

A. Consider the effectiveness of the different types of FSA health plans and recommend necessary changes in organizational patterns. In this assignment the committee will give close attention to the following questions:

   1. How much do participating families take part in the planning and administration of the plans?

   2. What is being done to give them more responsibility for the plans?

   3. Are their wants made known to professional groups? Through what channels?

Responsibilities (cont'd)

4. What type of professional organization(committees, etc.) has proved most effective?

5. How does the plan fit into other community activities directed toward health education and protection?

B. Compare various methods of payment for services; study and relate participation rates, professional charges, percentage of payments for professional services, and allocations of funds as between services, as well as the scope and quality of services. Recommend such adjustments in these various factors as may be necessary to increase membership, provide more adequate services, and increase percentage of payments for professional services. The committee will concern itself with such questions as these:

1. Are families not participating in plans because of limited services offered? Are they willing, and can they pay more for a comprehensive program?

2. Do physicians look upon plans as merely collection devices? What can be done to correct this impression?

3. What steps can be taken to improve scope and quality of services?

4. How is it proposed to solve, at least in part, the problem of heavy proration?

C. Recommend steps to secure better and more accurate reports from operating units, and ways and means of using reports effectively:

1. Are trustees and secretary-treasurers properly trained?

2. What can be done to improve reporting?

3. Should there be a manual of instructions to trustees and secretary-treasurers on the preparation of reports and their use as an educational medium with participating families and professional groups?

4. Are the Regional Health Services staffs taking enough responsibility in the preparation of comparative studies of plans for use by professional groups and others?

COMMITTEE REPORT

A. Effectiveness of Different Types of FSA Health Plans

In considering the effectiveness of the different types of FSA health plans operating in the United States, we wish to offer the following information and suggestions regarding changes in organizational patterns.

1. Planning and Administration - At the present time participating families do not appear to be taking enough part in original negotiations during the formation of health services plans.

The committee recommends that it be our general policy to include a representative committee made up of interested families which will plan negotiations for developing the proposed health service program, with whatever guidance may be made available through FSA, and will be kept advised of the progress of professional negotiations.

In the sections where the participating committees or health associations' directors are active, the health services plans appear to be operating more satisfactorily. It is the committee's opinion that for the continued success of the health program in rural communities, even more active member participation in the planning and administration of health services be encouraged.

2. Family Responsibilities

a. Many of the following actions are being successfully carried out in the various regions:

Regular meetings of a board of directors to review progress, discuss problems, handle routine business matters, and report progress to families and the professional groups.

Periodic discussions of the problems encountered in the operation of group health service plans by committees, representing the participating families and professional groups.

Use of health news letters to stimulate family interest in health and the operation of the health service plans.

Annual business, social, and educational meetings for the entire membership either in a series of community meetings or for the entire area covered, as best meets the local situation and problem of transportation.

Health talks to families, FSA personnel and others at every meeting that is held or attended. Usually these talks are for three minutes or less and stress one phase of health services.

b. The Committee recommends:

That these measures be continued in areas where used and that every effort be made to extend their use to other areas. That families assume more responsibilities in operating health services.

An enlightened membership is necessary to accomplish this end. Therefore, more frequent meetings of the participating families either in a general meeting or by community groups should be held or the information presented in all meetings called for any other purpose. The suggestion is made that a local or state representative of the department of health and a representative of one of the cooperating professional groups be invited to attend such meetings to discuss one phase of the health program as often as arrangements can be made.

3. Expression of Family "Wants" to Professional Groups - It is recognized that some efforts have been made to make known the "wants" and "needs" of participants to professional groups through boards of directors of health associations, committees of participating families, FSA personnel, and committees of the professional groups.

We do not consider that adequate representation has been given the participant families in expressing their needs. Family representatives familiar with and interested in the development of a health protective service program should be designated as a committee to advise with representatives of the professional group on the wants and needs of the participants.

4. Types of Professional Organizations - In developing a professional committee or advisory board for rural health services, the importance of clearing through the state medical society including the state medical council, the state medical economics committee, the public relations committee and the rural medicine committee, must be recognized.

It must also be recognized that doctors from towns and cities are more active in the state medical associations and generally more influential. Therefore, special attention should be given to the formation of a committee informed on the rural situation and sympathetic with the view of doing something to relieve the situation under which both rural families and rural doctors are handicapped.

Your committee recommends that professional committees be set up on a district or "medical trade area" basis in addition to any committees suggested by the county medical society. The wisdom of this recommendation will be recognized when it is understood that most refresher courses and improved medical practices are in connection with larger hospitals in such areas. These "areas" may preferably cover from three to ten counties.

It is further recommended that a joint professional advisory committee be developed on an area basis, with two or three members representing each profession, in order to coordinate the activities of each health service professional group.

A similar committee is considered desirable at the state level and at the regional level with representation from the different states.

5. Integration of Health Service Plans with Community Activities - It is important that the various types of health service plans be integrated with other community activities directed toward health education and protection. This can be accomplished partly by soliciting the aid of such agencies as state and local health departments, state nutrition councils, local Red Cross chapters, T.B. societies, local officers of the U. S. Public Health Service, maternal child health and welfare agencies, Blue Cross and Blue Shield plans, school officials and others.

It is recommended that the family governing body for the health service plan work out specific plans to acquaint community leaders and the public generally with the reasons for establishing the plan and what is expected to be accomplished.

6. Formation of Health Service Plans - In general, consideration should be given to the formation of health service units according to professional trade territories, district councilor areas, or any political or administrative sub-division lending itself readily to district organization. Families should be represented through elected delegates from the community, to the county, and through to the district board of directors. Fpr example, the chairman of the community health committee may represent that community on the county family governing body. The chairman of the county body may represent the county on the district board of directors of from five to eleven persons.

The committee recommends that we so report and study membership in established plans that any changes may be readily determined and the reasons therefor studied. In the establishment of new health service units, the reports should not be permitted to hide decreasing membership in units already functioning.

B. Recommended Improvements in Health Plan Patterns

The desirable program for health services should include medical care, surgery, hospitalization, drugs, dental services, home nursing, sanitation facilities, and laboratory facilities for all members of an association or program. However, the development may require the establishment of limited services for varying memberships and varying needs in different areas. Therefore, a rigid pattern for health services is not recommended for the Nation.

1. It is recognized that the fee-for-service plan is the plan most commonly used in determining amount of payments. Likewise, the weaknesses in this method are apparent in many areas under conditions of shortage of doctors and other health facilities.

   It is recommended that improvements in payment methods be studied in the fee-for-service plan as well as on the "per-family-served" basis, frequently spoken of as the "capitation plan", and a method of reporting be developed that will permit more careful comparisons.

   It is suggested that the "unit system" be explored. This system defines units of services and serves as a basis of payment. It is recommended, however, that the development of dental care plans on the clinic-period, hourly compensation basis be continued and carefully studied. The necessity of employing full or part-time professional assistance in certain areas and under certain conditions is recognized.

2. Allocation of funds can best be determined only after costs for various types of services have been determined separately and the ability and willingness of families to pay for these services have been studied. If the total funds required to carry on the planned health services exceed the families' ability to pay, adjustments in types of services or revision of costs covered by the agreement will be necessary. In cases where the maximum family payments do not constitute sufficiently adequate payments for carrying out the planned health service, the possibility of supplementing these funds from tax funds through township trustees, county courts, appropriate state funds or federal grants should be explored.

3. Special emphasis should be given to preventive measures such as early diagnosis, immunization, sanitation and nutrition in order to improve health conditions and thereby decrease need for services and increase percentage of payments to professional groups.

4. It is recommended that increases in participation rates in any county should be agreed to only when such increases will provide better quality of services or additional services, unless these rates now are obviously too low to carry on the service plan as it is operating.

5. In order to increase the family participation in the health service plan or association, it is suggested that the most adequate health services program possible for the area be developed, that an educational program directed toward professional groups, FSA personnel, and eligible families be devised and maintained, that each farm and home plan make specific provision for health services in those areas covered by the plan.

6. Where it meets the approval of the professional groups, membership should be extended to all low and moderate income rural families in the area. Steps should be taken to obtain adequate participation from all such families in the area in order to protect the plan or association from unreasonable liabilities due to an abnormal incidence of illness.

7. It is suggested that consideration be given to payments to professional groups on a quarterly basis, where feasible, as a method to equalize variations in percentage of payments and to reduce costs of accounting.

8. On account of the increasing requests upon the regions being made by other organizations for information pertaining to organization of group medical care programs, it is recommended that proper literature be prepared for distribution for this purpose.

C. Reporting of Health Services

In considering recommendations relative to reports and reporting systems, the committee has made an effort to keep in mind the various needs and problems of the county offices and personnel, the regional personnel, and the office of the Chief Medical Officer in Washington, in order to render more effective reports which will prove of value to all concerned.

Again, let us emphasize that by health services, the committee is including all phases of the health services program designed to protect or improve the health of participating families.

In order to secure better and more accurate reports and ways and means of using reports effectively, the following recommendations are made:

1. That a manual be prepared by the proper persons (i. e., all health service personnel concerned, together with others familiar with the problem) to be used by trustees and secretary-treasurers of associations. It is suggested that this manual, in addition to FSA procedure, explain duties in developing and managing a health program, and that it be thoroughly and personally explained to those responsible for a program at the time services are started.

2. That the form "Administrative Supervisor's Survey Guide Sheet" include a section on health services activities in order to complete in detail a check on these activities in the county office by the administrative and assistant administrative supervisors.

3. That there be incorporated in the Monthly County FSA Activity Report (Form 322) a separate health services section giving information regarding progress of the county office in establishing complete health services programs, and that this report be included in the Monthly Report of FSA Activities prepared by the Program Analysis Unit.

4. That instructions on a national procedure for health services be issued, outlining broad major policies with provisions for supplementary instructions to be issued by the regions.

5. That the report submitted by Supervising Accountants be reviewed by responsible persons in the regional offices and returned to the county supervisor with fitting comments. These comments should be designed to guide trustee and local FSA personnel in presenting reports to doctors and governing bodies, and additional comments should be made on the recommendations made in the reports.

6. That in counties where different numbers of members are enrolled in several health services, a separate Form 204 should be prepared for each group of members receiving the service, and in all other cases where the same groups of members are receiving all the services, one Form 204 report should be submitted.

7. That the semi-annual and annual Form 204 reports be eliminated. That a special form and proper instructions be prepared for an annual report to be submitted at the end of each association's fiscal year or as of July 1 of each year. The time for reporting should be fixed in each region as best adapted to its needs.

8. That additions be made to the Form 204 to include information on kinds of surgical cases, volume and type of dental services, sanitation records, and provisions for showing accumulated surpluses carried forward from any period or year.

9. That the Regional Program Analysis Section assemble data (the Form 204 reports) for the Health Services report and forward same through the Regional Health Services Specialist to the Chief Medical Officer in Washington. If this arrangement cannot be made, administrative request should be made for assistance in the Health Services Section in regions with a sufficient number of operating counties to justify an extra person to handle these reports currently.

10. That consideration be given by the Washington Office to the possibility of furnishing the regional health sections with progress reports quarterly, covering activities of all health programs, summarized by state and region. The regions should, further, prepare summaries pointing out facts and observations important to the development of programs for distribution to state and area staffs and other personnel, where plans are in operation or being developed.

11. That each region provide 15 copies of its typical, representative accounting forms and bills used to the Chief Medical Officer for distribution to all other regions for their study with the possibility in mind of unifying as many of the forms as practical at this time.

12. That favorable consideration be given to encourage county programs or health associations to distribute quarterly news letters among members and professional personnel, giving local information and taking into account such items as membership status, service rendered, human interest stories, financial status, and from time to time when considered advisable, information on the progress of other programs in the state.

DISCUSSION

Need for Family Responsibility

The immediate urgency of stimulating assumption of member responsibility for the management of plans was stressed. The particular necessity at this time, it was realized, is heightened by the possibility of curtailment of the entire FSA program in the coming period. The valuable organizational accomplishments in the extension of rural medical care, developed over the past seven years, may be lost unless a widespread policy of self-management of plans by member families is put into effect at once.

Medical Trade Areas and District Plans

The concept of "medical trade areas" or "medical service areas" was favorably received by the conference. The implications of this plan of rural health organization for the post-war period were fully appreciated. It was felt that the organization of this distribution of health services under FSA programs could provide a basis which might prove valuable as a pattern for all public health, hospital, and medical service organization in the coming period.

In this connection the advisability of fully exploring the possibilities of amalgamation of county units into larger district associations was generally recognized. The importance of this was seen in order to promote the solvency of the plans and stabilize them generally. It was appreciated that, in the long run, benefits could best be extended if risks are pooled over larger numbers of subscribers than are now indicated in the average county health association.

Method of Payment of Physicians

While the prevalence of the fee-for-service system of payment of physicians was, of course, realized, considerable interest was displayed in the exploration of new methods. The capitation system was recognized as particularly valuable in areas where competition among participating physicians was particularly great (such as near urban centers). Often, in such areas, no system of payment has been found as effective in winning the cooperation and mutual trust of the practitioners as the capitation system.

III. THE WAR AND THE FSA HEALTH PROGRAM

Committee Members

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Lawrence Lamb, Denver, Colorado

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Fred W. Morse, Jr., M. D., San Francisco, California

M. I. Roemer, M. D., Washington, D. C.

Matilda Ann Wade, R. N., Washington, D. C.

Responsibilities

A. Explore the effects of war on agriculture with special reference to the FSA program. Some questions which will arise in connection with this assignment are:

   1. How has the shortage of medical and related services affected our health program?

   2. What is being done to meet the problem?

   3. How could the FSA cooperate with other agencies in seeing that rural medical care needs are met?

   4. Since grant funds have been curtailed, what is being done by county personnel to take care of correctible chronic conditions and medical care not covered by the plans?

   5. Have enrollments been affected?

   6. Are field personnel carrying on the health program as well as they did a year ago? What assistance is being given them to adjust the program to the war changes by Regional Health Services personnel?

B. Consider the special wartime problems we face in providing physical examinations and certain medical care measures for seasonal and year-round farm labor.

COMMITTEE REPORT ON GENERAL EFFECTS OF THE WAR

A. Preamble

Farmers have more work and less help to do the job of food production which all the world needs. At the same time they are being deprived of their fair share of medical and dental services. While farm mothers and children will be doing more and harder work than ever before, their effective doctors and dentists are leaving the rural areas. Meanwhile, the armed forces and many industrial workers are being provided with the best in health care -- as they should be. Yet the Nation must do the best it can to care for the strength of American farm men, women and children in order to insure the greatest possible food production.

B. What Needs to be Done?

1. The farmers need to be apprised of the fact that doctors and dentists could be recruited from cities where there may be one doctor to every seven hundred persons and placed in farming areas where there is often no doctor at all or only one to several thousand people.

2. Also, the American farmer needs to be apprised of the fact that doctors, as anyone else, need a reasonable guarantee as to income and living conditions if they are to move into medical shortage areas.

3. Then the American farmer needs help to organize his neighbors in effective groups with purchasing power sufficient to pay the physician or the dentist that he needs, if vast rural areas are to be supplied with needed services.

To do less than this means that farmers in many areas will suffer without needed care and fail to raise crops, leaving more hunger in our cities. If this is not done, federal handling of doctors and dentists under government salary may be necessary.

C. A Practical Plan

1. County War Boards in doctor-scarcity areas should be acquainted with the health and medical care problems in their counties. Regional FSA health specialists may play a role in this task.

2. After having the facts, the County War Board would issue a call for doctors through the State Medical Society and the State Procurement and Assignment Service.

3. The organization of health associations for prepaid medical care could provide an income guarantee for doctors or dentists being asked to settle in a new area.

4. Copies of all requests from County War Boards to State Procurement and Assignment Services should be sent to the national Procurement and Assignment Service and the Surgeon General of the U. S. Public Health Service.

D. What Else Can Be Done?

1. Physicians employed in U. S. Public Health Service and State and County Health officers can be freed of bonds which at present prevent them from caring for the sick. This is needed badly in the care of land armies, and year-round farm laborers. It would relieve the doctor shortage in many rural areas.

2. Health Education.

   a. Distribute literature on self-care to farm families.

   b. Give first aid and home nursing courses not only in connection with civilian defense efforts but to alleviate the doctor shortage.

   c. Distribute information about needed medical supplies such as the American Medical Association "Home Medicine Cabinet".

3. All existing agencies should make a closer pooling of efforts on the rural health front, including FSA, USPHS, public welfare agencies, public schools, Red Cross, Blue Cross hospital plans, State and county health departments, etc.

4. In some instances, a doctor or a dentist from a neighboring county can spend one or two days a week in a doctor-shortage area. Medical and dental societies and Procurement and Assignment Service should assist in thus effecting a more equitable distribution of doctors and dentists.

5. Present health care groups that have been organized by FSA in one-third of the U. S. counties should be opened to more farmers through consent of local medical societies. This would place more farmers in definite prepaid medical care plans and wash out the temptation facing rural doctors to locate elsewhere because of better income.

6. Increase enrollment of FSA farm families in existing rural health care groups. In some areas a limited Federal subsidy should be available if the small farmers are to be members and have needed health care.

7. Save doctors' time by patients going to office and hospital instead of calling doctor to the home.

This statement is based on an all-out war effort to produce the maximum amount of food for ourselves and our Allies which can only be done through giving the best possible health care to the women, children and those men who are left behind to do the farm work. The statement is based upon the premise that the only safe way is to plan for the possibility of a long war.

DISCUSSION

Shortage of Physicians

The importance of doing something constructive about the shortage of physicians and other medical personnel in rural areas was repeatedly stressed through the entire conference. Many rural people, it was pointed out, feel it is their patriotic duty to do without medical services, since professional personnel are serving the armed forces. We are faced with the task, therefore, of helping them to understand that their primary patriotic duty is to keep in good health and that it is up to them to demand that the full resources of the Nation be utilized for the promotion of the farmer's health.

At the same time, it is necessary to help the rural population adjust to the medical shortage by maximum utilization of other community resources.

Cooperation with Other Agencies

Maximum utilization of other community resources means the closest pooling of efforts by FSA and other agencies in the county. It is not enough to pay lip service to the idea; actually functioning committees must be set up to develop local activities such as: obtaining part-time services of doctors from neighboring communities, establishing centralized telephone exchanges for doctors, organizing and conducting first-aid and home-nursing classes, extending the services of various public health clinics, distributing literature on when to call and when not to call the doctor, etc. The results of coordinated efforts are far greater than those of the isolated operations of numerous independent agencies.

IV. THE EXTENSION OF RURAL HEALTH SERVICES

Committee Members

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Subcommittee of Special Health Program Managers

O. E. McGilvray, Linden, Texas, Chairman

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Responsibilities

A. Evaluate the lessons we have learned from the experimental programs and relate them to the FSA health program.

B. Propose steps for extension of our health program to non-borrowers, with recommended procedures for enlisting the support of professional groups, Blue Cross plans, other farm groups, and local agencies. Standards of eligibility, scope of services, rates for participation, etc., should be clearly set forth by this committee.

COMMITTEE REPORT

Committee Number Four makes the following report on the lessons and experiences gained from the Experimental Health Programs together with proposed extensions of other Health Service Programs.

A. Lesson and Experiences from the Experimental Health Programs.

The Committee discussed the reports on the organization and operation of the Experimental Health Programs and believes the following experiences or lessons are sufficiently important to act as guides to future operation and organization of additional programs.

1. The response of the public indicates existence of a wide demand and need for extension of health services in rural areas. This is evidenced by the fact that in the majority of counties more people wished to enroll than could be covered by the subsidy.

2. Experimental programs have demonstrated that the people, through their Boards of Directors and the professional groups, involved can, in a democratic manner, work out the problems involved in the organization and operation of health programs.

3. The operation of these programs has proved the need for a person engaged to assist in their organization and development. Such a person should know the local situation, the people involved, their problems, and should be on the ground when the program is first started. Full time managerial service is essential to the operation of such programs. The extent to which a full-time man can be employed will depend up the volume of membership and the amount of funds available. Under no condition should an employee of any association be a member of the Board of Directors or a relation of any member thereof.

4. The proper technical assistance and guidance from persons trained and experienced in the organization and management of such programs should be available to local groups setting up and operating these programs.

5. The rate of contribution of these families should be related to their ability to pay.

6. The inability of some families to pay the full rate of participation proves the need for outside financial assistance or subsidy.

7. Medical trade areas, rather than county lines, should determine the boundry lines of these associations.

8. The membership should contribute to its maximum ability toward the support of these health programs. It has not yet been determined what percent of its income the family should pay.

9. The prepayment principle is of definite value as a method of financing health services.

10. Rural health centers are practical and desirable and their increased organization should be encouraged, especially during the war period in order to improve the quality of professional services, to make these services more readily available, and to conserve the time of professional personnel.

11. Nursing services should be expanded to provide for at least one nurse to 5,000 people. Greater emphasis should be placed on educational bedside nursing and the teaching of home hygiene and care of the sick to high school pupils and to classes of adults where such can be organized.

12. There is need of greater emphasis on preventive medicine and the maintenance of positive health by means of improved nutrition, sanitation, and immunization, coupled with health education and periodic physical examinations.

13. The Experimental Health Programs are not meeting the complete health needs of members of the rural community because of:

a. Shortage of physicians, dentists, and nurses.
b. Lack of recent refresher courses on the part of members of the profession.
c. Insufficient funds.
d. Improper allocation of available funds.
e. Inadequate clinical and hospital facilities.
f. Lack of proper environmental sanitation facilities.
g. Inadequate public health services.

14. The provision of essential drugs constitutes one of the major problems in operation of Experimental Health Service Programs.

15. Family participation fees should be paid annually and in advance.

16. Professional services may be financed successfully on a salary (annual or per diem), capitation, or pool fund arrangement.

17. A proper bookkeeping and record system is necessary and this, in the early period of operation, should be kept to essential minimal data.

18. The lack of a well planned and continued information program by which the members are kept regularly informed of the activities and problems of their association is probably the greatest weakness of the present program.

19. Health services rendered through these programs show a lack of sufficient professional supervision and inspection.

B. Proposed Extension of Rural Health Services.

1. Inclusion of Non-FSA Borrowers.

The FSA group health programs should be extended wherever possible to include all low income families, both rural and urban in the following manner:

a. Secure approval of local professional groups and the local health association, to make such a change.
b. Work out details of the change at a joint meeting of representatives of both groups and set up a temporary organization to carry on the membership drive.

c. Designate local committees and secure the cooperation of local community organizations to carry the responsibility of informing everyone of the proposed plan and how it operates.

d. The revised program should be placed in operation as soon as possible after the plan of expansion has been decided upon; preferably not more than 60 or 90 days from the date the membership drive is launched.

2. Blue Cross and Other Group Hospital Plans.

Acceptance of such proposals should be considered only after negotiations direct with the local hospitals involved have failed to develop services and rates more advantageous to the members.

3. Local Groups and Agencies.

The Health Association should utilize to the fullest extent all services and facilities of existing health agencies, both official and non-official.

4. Eligibility Standards.

Standards of eligibility should be as liberal as possible, taking into consideration the need for the cooperation of professional groups and participation of low-income families.

5. Scope of Services.

Every group health program should, if possible, include all phases of health care, both preventive and therapeutic. If this goal cannot be reached, the services listed below should be considered:

Physicians' or dental services
Surgeons' services
Hospitalization
Essential drugs and biologicals
Nursing services
Environmental sanitation

Ambulance services
Public Health services
Diagnostic laboratory services
Health centers

6. Participation Rates.

In arriving at family participation rates, the following factors should be taken into consideration.

a. Health needs of the people involved.
b. Estimated normal income of the professional group concerned.
c. Type and scope of services available.
d. Ability of families to pay.
e. Amount of charity work now being performed by the professional groups.
f. Probable number of families involved.

C. Report of the Managers of the Experimental Health Program
At a meeting of the Managers of the Experimental Health Programs, the following phases of the program were discussed:

1. How to select members - Since it is anticipated that there will be more applications received than funds available to care for the needs of the health program, it was decided by the Managers that the members should be selected numerically as applications reached the offices of the associations.

2. Definition of a family - A family is defined as comprising the members of one household, dependent for support on the head of the family.

Are members of a household, who are employed, eligible for service on the family membership card? They are when this income is added to that of the head of the family, to give a sum which is used in arriving at the family payment.

3. How should Social Security and the Victory Tax be handled? It was decided that each member should get in touch with his regional attorney to secure information concerning this matter.

4. Information - Plans for getting information out to the family for the coming year:

a. Families should be contacted and meetings held in schools, churches, and community centers.

b. Through the use of local newspapers.

It was agreed by all Managers that they would furnish other Managers of the Experimental Health Programs as well as the Washington office, with all general information mailed to their members.

5. Payments - Average family payments and anticipated average family payments for 1943-1944:

County	Anticipated Payment	Last Year's Average Payment
Wheeler County, Texas	$26-	$21.56
Cass County, Texas	20-	9.72
Newton County, Mississippi	15-	6.14
Walton County, Georgia	20	11.25
Nevada County, Arkansas	15 -- 16	7.84
Taos County, New Mexico	7 -- 10	3.65

If the Taos County, program does not receive a grant, it is anticipated that a family collection of $30 will be made in order to continue the program, now in operation.

6. Vital Statistics - The question was raised as to whether or not babies born to families after becoming members of the association should be included in the monthly reports. Mr. Yaukey cleared up this matter by stating that the number of babies should not be included in the monthly report, since this figure might be offset by deaths occuring during the year's operation of the program.

7. Accounting - How should cash, received from investments of an association's funds, be credited? It should not be credited to refunds, but should be applied to a contingent fund, where such situations exist.

How should balances arising from the overpayment of bills be handled? For example, after all general practitioners' bills have been paid for February, and overpayment is discovered, how should these funds be handled? Answer: the fund is prorated among all general practitioners on a percentage basis, derived from the total approved bills.

8. Farm Plan - A suggested farm plan was presented by one of the managers for approval. This farm plan was approved by all managers for use in that particular locality. It was also decided that each association should have its own farm plan drawn up to fit the locality in which the association is located.

9. Drug Problem. It was recommended that:

a. There should be a total fee of $7 per family per year.

b. A small percentage of the drugs used should be paid for by members of the association in order to curtail possible abuse by members and professional groups. As there was considerable discussion on this matter, it was decided to vote on it. A motion was made by Lester L. Tuck of Mississippi and seconded by Mr. Dewoody of Arkansas, that a small percentage of drugs used should be paid for by association members. It was put to a vote, approved, and carried by a majority.

10. Medical Advisory Committee - The question was then raised as to whether or not a general practitioners' committee was feasible. It was decided thal all associations need a general practitioners' committee for protective pruposes. It was also decided that these committees would be used in instances when general practitioners' bills are questioned by managers.

11. Shortage of Medical Personnel - It is recommended that the Washington office investigate the assignment of doctors and dentists by the U. S. Public Health Service to areas which have a ratio of 5,000 persons or more to one general practitioner and a similar scarcity ratio for dentists.

12. Environmental Sanitation - It is recommended that associations be considered as pools for the disbursement of environmental sanitation funds, provided that supervision be under proper construction superintendents.

13. Office Equipment - It is recommended that some provision be made for county office equipment.

14. Dental Services - It is recommended that in no case should dental services be discontinued, if there should be a curtailment of the program due to a shortage of funds.

The Managers of the Experimental Health Programs wish to thank the Washington and regional personnel for the splendid help and cooperation given to them during the past year's operation.

Recommendation of Subcommittee on Membership Fee Formula for Experimental Health Associations.

In the course of the discussion of the report of the Committee on Experimental Health Programs, the question of a satisfactory formula to be used in estimating the membership or service fee to be paid by members during the second year of their operation (and by members of any new associations of this sort that might be formed) was discussed at some length.

Following this discussion a committee consisting of Mr. J. B. Yaukey, Mr. George Montgomery and Mr. Lester L. Tuck was appointed by the chairman to submit a report at the beginning of the afternoon session.

The recommendation of this committee was that the membership or service fee to be paid by each family be $12 on that part of the net cash income during the previous calendar year which is less than $100, plus six percent on that part which is $100 or over, but less than $500, plus eight percent on that part which is $500 or over and not over $800.

This indicates a minimum annual fee of $12 and a maximum of $60 with the fees between these limits ranging as follows:

Annual Net Cash Income		Annual Family Fee
Less than $100		$12.00
$100 to $199.99		12.00 to 17.99
200 to 299.99)		18.00 to 23.99
300 to 399.99)	6 percent	24.00 to 29.99
400 to 499.99)		30.00 to 35.99
500 to 599.99)		36.00 to 43.99
600 to 699.99)	8 percent	44.00 to 51.99
700 to 799.99)		52.00 to 59.99
800 or over		60.00

This schedule of family payments is recommended to the careful consideration of each association.

RESOLUTION

WHEREAS: The Experimental and Special Rural Health Programs under the auspices of the U. S. Department of Agriculture have been carefully reviewed with much interest by the conference, and

WHEREAS: Sufficient experience in the operation of these programs has been gained to justify their continuation and expansion, and

WHEREAS: Definite patterns for improved health service for rural families are being developed, and

WHEREAS: Further experience in the organization of such programs is necessary, and

WHEREAS: It is the consensus of this conference to study the extension of rural health services, therefore

BE IT RESOLVED: That there is urgent need for the immediate continuation and expansion of these programs within specific areas in order that the health of farm families be improved and conserved, and

BE IT RESOLVED FURTHER: That the organization of such plans be designed so that similar effective programs may be extended to other areas within the United States and other countries during the post-war period, in order that we be better prepared to meet the coming demands from the people and all the medical professions for more adequate health services.

Seconded, voted upon, and passed.

DISCUSSION

Public Health Nursing Program

Considerable discussion was devoted to the relationship of the public health nursing personnel of the Experimental Programs with the county health departments. In those plans with nursing services already established, the nurses have been attached to the county health department, with their services generally available to the whole community. It was maintained by some, however, that public health nurses should be employed directly by the associations for the purpose of serving member families only. Others maintained that the association should furnish funds to the county health department (where such exists) which should, in turn, furnish nursing services to member families, as a part of its whole county generalized nursing program, in proportion to the contribution. For example, if the total county health department public health nursing budget were $5,000, of which $2,000 had been contributed by an association, then two-fifths or 40% of the total public health nursing time of the health department should be devoted to the member families.

Whatever arrangement is made with local health departments, it was emphasized that association member families should receive services commensurate with the extent of their special contribution to the county health department budget. In most instances this means that member families would receive more services that other families in the county; it was felt that this supplementary service might be rendered in the form of bedside nursing (not ordinarily included in the regular public health nursing program of an official county health unit).

Comparison of Different Types of Special Plans

Special interest was noted in a comparison of the mode of operation of the plans in the six experimental counties as against that in the special FSA program in Taos County, New Mexico. In all but one of the "experimentals" the method of physician payment is fee-for-service, the remaining plan using a capitation basis. Although all conditions in the two sets of situations are not strictly comparable, the average family cost per year for Taos County appears to be significantly lower than the $50 to $57 charges for the other plans. The entire staff, therefore, views with interest this accumulation of field evidence on the question of the economies of salaried service.

Enrollment of Higher Income Families

The importance of enrolling in the experimental plans more families of higher income levels was appreciated, in the interest of promoting solvency. It was understood that grant funds might well be curtailed in the coming year, so that the entire subsidy program would be seriously affected. On the other hand, the opposition of physicians to the inclusion of any considerable number of higher income patients is to be anticipated.

To cope with this difficulty, the advisability of an "over-income" classification is to be considered. By such an arrangement, all income groups would be admissible to the plan--but those in the "over-income" classification would be subject to certain supplementary charges by the physician. This

system has operated successfully with some of the hospitalization insurance plans covering surgical services. Elevation in rates for all families is to be considered, as indicated in the special subcommittee report. In any event, the importance of further consideration of ways and means of including higher income families in the experimental plans was stressed. The advisability of including families in small towns was also considered.

Payment for Drugs

The wisdom of levelling certain charges for drugs against the family was seriously questioned by many members of the conference. Although a partial charge for drugs has been instituted in three of the six experimental counties, it was felt that this charge might act to deter families from seeking needed medical services promptly. Some statistical evidence substantiating this belief was available from recent experience with one of the counties.

While application of this partial charge was claimed to be effective in eliminating "abuses" by both families and physicians, careful observation of experience with both systems (with and without partial charges) is to be made before final decision is made on future policy. Much favor was expressed toward the idea of establishing standard local fee schedules for drug charges on a "cost plus" basis. This matter was to be further explored by the Washington office.

Annual Subscriber Fees

Some question was raised on the advisability of having the entire prepayment fee paid on an annual basis. Several persons suggested that payments be made on a quarterly or monthly basis.

In most areas rural families, through established credit facilities, might well be able to pay annual fees in advance. Some attention should be given, however, to the possible exceptions which might occur and the possibilities should be explored of securing payments on a quarterly or monthly basis through milk or other produce check assignments, salary deductions, etc. This might be particularly applicable to cases of farm laborers, sharecroppers, hired hands, and similar farm groups.